

UCI



Superior Vision Services, Inc.



Sandia
National
Laboratories

SF 4400-VIS (4-2001) Supersedes (1-2001) issue

Non-Network Claim Form

Top section to be completed in full.

Employee/Insured Name		
Name of Person Receiving Services		
Date of Birth of Person Receiving Services	Relationship to Employee/Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Full Time Student (over 18 yrs)* <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*Verification may be required</small>
Mailing Address		
City	State	Zip
Daytime Phone ()	Evening Phone ()	
Social Security Number of Employee/Insured	Authorization Number	

Instructions

1. Please complete this form in full
2. Submit your original itemized billing received from the non-network provider along with this form to:
**Superior Vision Services
P.O. Box 308
Rancho Cordova, CA 95741**
3. You will be reimbursed according to the schedule of allowances for non-network providers for your company.